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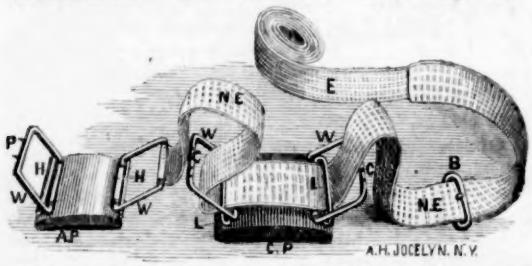

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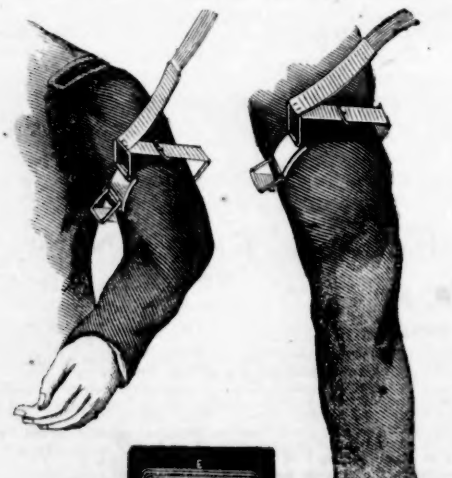

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Original Lectures.

LECTURES
ON THE
DIAGNOSIS OF DISEASES OF THE HEART.

DELIVERED AT THE
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SESSION 1862-63.

By AUSTIN FLINT, M.D.
PROFESSOR OF THE PRINCIPLES AND PRACTICE OF MEDICINE.

LECTURE VI.

Subdivision of the Second of the Heart-Sounds into an Aortic and a Pulmonic Sound.—The Study of these Two Components of the Second Sound separately.—Situations where the Aortic and the Pulmonic Second Sound are to be observed separately, and the Different Characters which belong to each Sound.—Weakening of the Aortic Sound, and Intensification of the Pulmonic Sound in Cases of Mitral Obstructive and Regurgitant Lesions, as the Means of Determining the Existence and Amount of Obstruction or Regurgitation which the Lesions Involve.—Weakening of the Aortic Sound as Evidence of the Damaged Condition of the Aortic Valvular Segments.—Inorganic, Anæmic, or Hæmic Murmurs.—Occurrence of the Mitral Direct Murmur without Mitral Lesions, and the Explanation of this Fact.—Explanation of the Relative Weakness of the Valvular Element of the First Sound, in Health, as Compared with the Second Sound.—Circumstances which Enable us to Determine whether an Aortic Direct Murmur be Organic or Inorganic.—The Venous Hum, or Bruit de Diable.

GENTLEMEN:—My two last lectures were devoted to the signs and symptoms involved in the diagnosis of mitral and aortic lesions. And, since my last lecture was delivered, I have brought before you, in the wards of Bellevue Hospital, cases exemplifying all the murmurs, together with the more important of the symptoms. Collecting together the patients in my own wards, and availing myself of the courtesy of my colleague, Dr. Greene, you have had the opportunity of leisurely observing the diagnostic phenomena in a large number of cases. You have listened to the mitral direct murmur existing alone; to the mitral direct and mitral regurgitant existing together; to the mitral regurgitant alone, and with the aortic direct murmur; to the aortic direct murmur and the aortic regurgitant murmur, each existing alone and associated. In some of these cases the diagnostic symptoms of disease of the heart are present in a marked degree, viz. dyspnœa, lividity, paroxysmal distress, dropsy, jugular pulse, visible pulsation of the arteries, etc.; in other of the cases more or less of these symptoms exist in a less marked degree; and in some of the cases scarcely any symptoms of cardiac disease are present. The ability thus to group together a large collection of cases illustrative of the stages, varieties, and phases of different diseases, is one of the great advantages of so large a hospital as this, adding immensely to the efficiency of didactic teaching. I shall again offer you the opportunity of examining these cases of valvular lesions, in order to review the differential characters of the murmurs, and to study an application of auscultation in such cases, of which I shall now proceed to speak.

I have been careful to state, in the two preceding lectures, that the murmurs which we have considered, important as they are by enabling us to localize lesions and determine, to some extent, their character, do not afford us much, if any, information respecting the gravity of the lesions which they represent. They do not enable us to form an opinion as to the amount of contraction of the orifices, as to the extent of valvular insufficiency, or even as to the existence of either contraction or insufficiency in certain cases. Let it always be borne in mind that we are never to judge of the importance of valvular lesions by the quality, or pitch, or intensity of existing murmurs. Is there no mode by which information may be obtained respecting the damage occasioned by these lesions? There is a mode, and it constitutes a beautiful application of auscultation. The mode to which I refer has reference to the heart-sounds; and, in order to prepare you to understand this application of auscultation, I must ask your attention to certain facts concerning the second sound of the heart in health.

The second sound of the heart we have seen in a previous lecture to be produced by the sudden forcible expansion of the segments of the aortic and pulmonic valves. The three segments at each of the two arterial orifices expand synchronously, and combine to form the second sound. A portion of this sound thus comes from the aortic, and a portion from the pulmonic orifice. Now, the aortic sound and the pulmonic sound may be separated from each other, and each observed separately. Let me explain how this is done.

In my first lecture, on the anatomical relations of the heart, I pointed out the relative course and situation of the aortic and the pulmonic artery. I have delineated these two vessels as they proceed from the heart, on the chest of the living subject now before you. Observe the aorta, at the point where the arch begins, is situated at a point corresponding to the second intercostal space on the right side close to the sternum. At this point it is most accessible. Were I to introduce a small knife in the second intercostal space close to the right margin of the sternum, and incline the point a little under the sternum, I should open the aorta. Now, if you place the stethoscope over this point, and the pectoral extremity of the instrument be not too large, you hear that portion of the second sound of the heart which is produced by the expansion of the aortic segments alone.

Observe that the pulmonic artery, as it leaves the heart, is deflected a little to the left; and observe that at the point where it goes backwards to subdivide, it is situated at the second intercostal space, on the left side, near the sternum. Here this artery is most accessible. A small knife introduced into the chest at this point, would open that artery. Now, the stethoscope placed over this point conducts that portion of the second sound of the heart which is produced by the pulmonic segments alone.

We have then an aortic and a pulmonic sound, combined in the second sound of the heart, and it is practicable to discriminate them in the way just described. What proof is there that this is practicable? The second sound of the heart, as heard in the two situations just mentioned, is not one sound, but two different sounds; that is, the second sound of the heart in these two situations is found to present differences in intensity, quality, and pitch, which show that the sound in each situation emanates from a different source; and, in view of the relations of the two vessels to the thoracic walls, it is fair to conclude that the sound on the left side of the sternum comes from the pulmonic, and that on the right side comes from the aortic orifice.

We may, therefore, distinguish the sound on the left side as the pulmonic, and that on the right side as the aortic second sound. What are the different characters which belong to the aortic and the pulmonic second sound of the heart? I will enumerate them and ask you to verify them for yourselves, by examining healthy persons with reference to this point. The aortic second sound is louder than the pulmonic; it is higher in pitch; it is apparently nearer the ear; it is shorter, and the valvular or clicking quality is more marked. *Per contra*, the pulmonic second sound is less intense than the aortic; it is lower in pitch; it is apparently more distant; it is longer, and the valvular or clicking quality is less marked. These differential characters are more apparent in some persons than in others, but you may easily satisfy yourselves of their correctness. The only character of importance to be recollected with reference to

the study of the two sounds in disease, is the intensity—the pulmonic is less intense than the aortic. The other characters are only important as proving the existence of the two sounds which are combined to form the second sound of the heart.

We are now to consider how the facts just stated lead to an interesting and important application of auscultation to ascertain the amount of danger occasioned by valvular lesions. We compare, in the first place, the aortic and pulmonic sounds in order to determine whether the mitral lesions represented by mitral murmurs involve contraction or insufficiency of the mitral orifice, and if so, to what extent? An effect of mitral obstructive and regurgitant lesions is to diminish the intensity of the aortic second sound. This effect is due to the diminished quantity of blood sent from the left ventricle into the aorta with each ventricular systole. The quantity of blood is diminished in proportion to the amount of obstruction or regurgitation. This is sufficiently obvious, and in proportion as the quantity of blood sent into the aorta with each ventricular systole is diminished, the aortic second sound is weakened. Diminished intensity or weakness of the aortic second sound is then a sign that mitral lesions are either obstructive or regurgitant or both.

The weakness of the aortic second sound may render the pulmonic relatively the more intense, but this mitral disparity is increased by another effect of obstructive or regurgitant mitral lesions, viz. an increase or intensification of the pulmonic sound. How is this effect produced? Obstructive and regurgitant mitral lesions, as we have seen, lead first to enlargement of the left auricle, next to pulmonary congestion, and next to hypertrophy of the right ventricle. Now, when they have induced the latter effect viz. hypertrophy of the right ventricle, the blood is propelled from this ventricular cavity into the pulmonic artery in larger quantity and with more force than in health. Moreover, owing to the distension of the left auricle there is an obstacle to the free passage of blood through the pulmonary circuit. The consequence is, the valves of the pulmonic artery are dilated with abnormal force; the force of the recoil is proportionately increased, and the pulmonic second sound is intensified.

Weakening of the aortic, and intensification of the pulmonic second sound, are thus effects of obstruction and regurgitation arising from mitral lesions. We can readily ascertain these effects by comparing, by means of auscultation, the aortic and the pulmonic sound. We listen to the second sound of the beat successively in the second intercostal spaces on the right and left side of the sternum, and we find the pulmonic sound to preponderate over the aortic in intensity, more or less, according to the diminished quantity of blood sent into the aortic, and the amount of hypertrophy of the right ventricle. The greater relative intensity of the pulmonic sound becomes a criterion of the amount of either obstruction or regurgitation, or of both, incidental to mitral lesions. For this truly beautiful application of auscultation we are indebted to Skoda, of Vienna. I shall give you an opportunity of making the application in the cases of mitral lesions now in hospital.

A similar comparison of the aortic and pulmonic second sound is applicable, for the same end, in cases of aortic lesions. Suppose we find, on examining a patient, the aortic direct murmur. This murmur may be due to lesions which occasion more or less obstruction, or it may be due to lesions which are innocuous, or, again, as we shall presently see, it may exist without any lesions whatever. The characters of the murmur give us no definite information respecting the conditions on which it is dependent. An aortic regurgitant murmur shows regurgitation, but the murmur gives no definite information as to the amount of regurgitation; the regurgitant amount may be small or large. Now, it is desirable to know whether the lesions situated at this orifice are of a nature to impair, to a greater or less extent, the aortic valve. Does this valve fulfil its function, and, if not, is it damaged much or little? A comparison of the aortic and pulmonic second sound affords us information with respect to this point. If the valvular segments are not affected, the aortic sound is not weakened, but preserves its normal predominance over the pulmonic. But if, on the other hand, the segments are more or less damaged, the aortic sound is proportionably weakened, and the pulmonic sound becomes, relatively, more intense. The morbid disparity is due, in this case, altogether to weakening of the aortic, and not to an intensification of the pulmonic sound, as in the case of mitral lesions. This is one useful application of the comparison of the two components of the second sound, and our cases at the hospital will also afford practical illustrations of which you will have the opportunity of availing yourselves.

The remainder of this lecture, gentlemen, I shall devote to an important subject connected with the cardiac murmurs. We have thus far considered murmurs which represent organic lesions of the valves or orifices of the heart. But, as I have intimated already more than once, an endocardial murmur may exist without any organic lesions. An abnormal condition of the blood may give rise to a murmur, the valves, the orifices, and the heart, in every respect, being perfectly sound. Such a murmur is distinguished from the murmurs due to lesions of some kind, as an *inorganic murmur*; or, since an inorganic murmur depends on some blood-change generally connected with anæmia, it is often called an *anæmic murmur*. It is also called a *hæmic murmur*. You will, perhaps, imagine that the occurrence of murmur without lesions, must give rise to difficulty and confusion in discriminating an inorganic murmur from those which are due to lesions; the latter, by the way, are distinguished as *organic murmurs*. The discrimination involves less difficulty than you may imagine, and, practically, the occurrence of inorganic murmur occasions no serious inconvenience in diagnosis.

Let me proceed at once to give an account of murmurs which may be produced without lesions. A mitral direct murmur may occur without any *mitral* lesions. I am not aware that any one before me has pointed out this fact. I know it to be a fact. I have met with two examples of this murmur, well marked, in cases in which examinations after death showed the mitral valve and orifice to be entirely free from lesions. In both these cases, however, there were aortic lesions involving insufficiency, and dilatation of the left ventricle. So far as my experience goes, therefore, the mitral direct murmur may exist without *mitral* lesions, but not without aortic lesions. I was at first at a loss how to explain the fact just stated, but reflection on the subject has led to an explanation which is to my mind satisfactory. It is as follows:—Distension of the ventricles with liquid causes the valvular curtains to float towards the orifices and to come into apposition. In fact, experiment shows that the auricular valves may be closed by injecting a liquid into the ventricles from the auricles. This experiment has already been made before you by the professor of physiology. Now, in cases of aortic regurgitant lesions, the left ventricle is already filled with blood by the regurgitant current at the instant when the mitral direct current takes place; and as a consequence, the valvular curtains are already in apposition Hence, the mitral direct current throws the curtains into vibration, and the murmur is produced. The mitral direct murmur, under these circumstances, and indeed generally, has a peculiar character, due, as I suppose, to the fact that it is produced by vibration of the valvular curtains, and resembling the sound caused by permitting the lips to be thrown into sonorous vibrations with the expired breath.

Let me here make an incidental remark with reference to the valvular element of the first sound of the heart. In speaking of the mechanism of the production of this element in a previous lecture, I was careful to say that it was due to the sudden *tension* of the auricular valves. I did not say the *expansion* of these valves. This element of the first sound is considerably weaker than the second sound of the heart. Whenever we eliminate from the first sound the element of impulsion, the second sound becomes the more

intense of the two. The second sound is propagated further from the præcordia than the first sound, because the valvular element of the first sound alone is propagated even for a short distance; the element of impulsion extends but little beyond the præcordia. These clinical facts appeared to me for some time quite inexplicable; but they are now to my mind explicable. The element of impulsion being due to the movements of the apex against the thoracic valves, is limited to the præcordia for the same reason that, as we shall hereafter see, a morbid friction sound is thus limited: and the relative feebleness of the valvular element of the first sound, as compared with the second sound, is due to the fact that the mitral and tricuspid curtains are already floated out and in apposition when the ventricles contract. The blood in the ventricles, when the ventricular systole takes place, does not expand the curtains protecting the auricular curtains—they are already expanded—but they are simply made tense: hence, the sound produced is weaker than the second sound of the heart, notwithstanding the aortic and pulmonic segments are much smaller than the mitral and tricuspid curtains.

To return to the consideration of inorganic murmurs. A mitral regurgitant murmur, and an aortic regurgitant murmur, are never inorganic; the occurrence of regurgitation at these orifices, of course, involves lesions which render the valves more or less insufficient. It is never a question when these murmurs are present, whether they are organic or inorganic. Thus the question, whether an existing murmur be organic or inorganic (exclusive of the mitral direct murmur), relates only to the aortic direct murmur. An aortic direct murmur may be either organic or inorganic. It is determinable in individual cases, whether this murmur be organic or inorganic? In general, this discrimination may be made; but it must be confessed that sometimes it is difficult, and even impossible. Does not the liability, in certain cases, to confound the two murmurs, impair the value of the organic murmur as a sign of aortic lesions? It does not; because, in the cases in which it is difficult or impossible to determine whether the murmur be organic or inorganic, it is of very little practical consequence to make the discrimination. Let me explain this statement:—

If an aortic direct murmur exist in a case in which the heart is found to be enlarged; if it be associated with an aortic regurgitant murmur; if the aortic second sound be impaired, the aortic direct murmur is in all probability organic—aortic lesions are present. But if the murmur exist in a case in which the heart is not enlarged; if an aortic regurgitant murmur be not present; and if the aortic second sound be not impaired, the murmur may be either organic or inorganic; and it is of little practical consequence to determine whether it be organic or inorganic, for, if it be organic, the lesions which give rise to it are innocuous. In other words, whenever the lesions giving rise to an aortic direct murmur are of immediate importance, the heart is more or less enlarged; or an aortic regurgitant murmur coexists; or the aortic second sound is more or less impaired.

In most cases, however, we are able to decide that an aortic direct murmur is inorganic. What are the circumstances which go to show that it is inorganic? I will enumerate the most important. And, first, I have already mentioned three important negative circumstances, viz. absence of cardiac enlargement, of an aortic regurgitant murmur, and of diminished intensity of the aortic second sound. These negative circumstances are to be considered as rendering it probable that the murmur is inorganic.

The existence of anæmia is another circumstance. Inorganic murmurs are generally associated with the obvious appearances of anæmia, viz. pallor of the prolabia and face. Anæmia, however, may exist without marked pallor, and, on the other hand, the murmur is found only in a certain proportion of the cases of well marked anæmia.

An inorganic aortic direct murmur is apt to be associated with an inorganic *pulmonic* direct murmur. We recognise the existence of a murmur in each vessel by disparity as regards pitch and quality. The coexistence of the two murmurs is a circumstance rendering it probable that the aortic direct murmur is inorganic; that both murmurs are due to the same blood-change. I may remark here that a pulmonic direct inorganic murmur not very unfrequently exists without an aortic direct inorganic murmur.

An inorganic murmur is generally soft; yet it is sometimes rough. Roughness, undoubtedly, renders it probable that the murmur is organic. A more important circumstance is the fluctuating character of the murmur. An inorganic murmur varies in intensity at different times, and may be sometimes wanting. An organic murmur is more uniform in intensity, and is almost always uniformly present.

In the cases in which an aortic direct murmur is inorganic, murmurs in the different arteries are generally found—in the carotids, the subclavian, etc. The same blood-change which occasions a murmur at the aortic orifice, gives rise to these arterial murmurs. It is generally easy to determine that the latter are produced within the arteries, not transmitted from the aortic orifice, by differences as regards pitch, and sometimes as regards quality.

Finally, certain cases in which an inorganic aortic direct murmur exists, are characterized by the coexistence of a murmur in the cervical veins. The murmur in the veins is a continuous humming sound, generally known as the *venous hum*. The French term it the *bruit de diable*, but by this title no disrespect is intended to his Satanic majesty. The devil in French is a child's toy—the humming-top—to the sound of which this murmur often bears a close resemblance. The murmur is sometimes loud and musical. It is heard on the right side of the neck oftener than on the left, and is frequently heard only when the patient is sitting or standing, not in the recumbent posture. For its production it is generally necessary that the stethoscope should be applied over the veins of the neck with a certain amount of pressure.

The venous hum was for some time supposed to emanate from the arteries of the neck. Some of the French observers still consider it an arterial murmur. That it is venous may be shown by a very simple procedure. In a case presenting the murmur, slight pressure above the situation where the stethoscope is placed, will cause an immediate suspension of the murmur, which reappears the instant the pressure is removed. It may thus be made to come and go by making and removing the pressure of the finger.

The venous hum is dependent on the same blood-change which occasions arterial murmurs, and an inorganic aortic direct murmur. It coexists often with a carotid murmur, and the latter continues when the venous hum is suspended by pressure above the stethoscope. Its coexistence with an aortic direct murmur is a point in evidence of the latter being inorganic.

Army Medical School.—The winter session of the Army Medical School, at Fort Pitt, Chatham, was opened on Wednesday, October 1, when the whole of the students belonging to the school attended in the lecture room. The introductory address was delivered by Professor Parkes. By direction of the War Office authorities the course of study at this school, during the present season, is to be confined exclusively to the junior assistant surgeons of the army. On Wednesday, twenty-seven medical candidates for commissions, and six assistant surgeons, joined the establishment to go through a course of medical instruction. —*Brit. Jour.*

The alkaline treatment of acute rheumatism appears hitherto to have been untried in France. M. Jacond, of Hôpital Beaujon, has, however, tried it in six cases, and pronounced himself satisfied with his attempt. "On the third day, the fever was diminished, the pulse was lowered, and the temperature of the body nearer the normal; but the most striking phenomenon was the rapid diminution, not the disappearance, of the pain."—*Brit. Jour.*

Original Communications.

REMARKS ON ALBUMINURIA,

MADE BEFORE THE NEW YORK ACADEMY OF MEDICINE.

By A. CLARK, M.D.,

PROF. OF PRACTICE AND PATHOLOGY.

(*Continued from* p. 258.)

In thirty-four uncomplicated cases, it was pale in 17; of sherry or high color in 7, in two of which very red; and of natural color in 10. In these cases it was often turbid, whether pale or high-colored. In twenty-three cases of heart complications, first examinations, it was of high color in 12; pale in 6; natural in 4; and smoky in 1. It was often turbid. In four cases of cirrhosis it was red, apparently with purpurine in 3; rather pale in 1. In four cases of phthisis it was three times high-colored, and once pale. In two cases of paraplegia it was about natural. In two cases of acute mania it was natural in one, and of a brown color in the other.

The examinations reported here, with the exception of the few which were repetitions after a few days, were all first examinations, and in most cases were made anterior to any treatment.

Albumen was found in quantity varying from a mere trace to sufficient to solidify the fluid 85 times in these 108 observations. *In twenty, casts were found, but no albumen.* In two neither casts nor albumen could be discovered; and in fourteen, casts could not be found, although the urine was albuminous. In one, there were albumen and fatty cells; and in one, fatty cells without casts or albumen. As to the *character of the casts*, in forty-two instances hyaline, or perfectly smooth and transparent casts were found. In just one half of these cases the hyaline casts only were found, while in the other half they were associated with granular and fatty casts, chiefly the former. Granular casts were found in forty-one; fatty in fourteen. Many of the latter were also granular. Nuclei were found attached to the hyaline, or oftener to the granular casts, in seventeen; granular or fatty cells much more rarely. Blood casts were noticed five times, and invaginated casts three times.

In twenty of the cases of heart disease, the character of the casts was as follows, viz. hyaline only, 1; granular only, 6; fatty only, 2; hyaline and granular (finely granular) in the same specimen, 9; granular and fatty, 1; hyaline, granular and fatty, 1. In two of the cases of heart disease albumen was not found.

As to the cases in which albumen existed and no casts were found, it is proper to say that often in office and consultation practice there is not an opportunity to make repeated examinations. The patient lives, perhaps, at a distance, and spends but a day or two in town; or a consultation in town is called once, and is not repeated. Then again, the specimens sent are not always the most favorable to a correct knowledge of all the facts. When the secretion has been standing for some time in a vessel, and a phial is filled from the surface fluid, the sedimentary matters, including the casts, may have subsided sufficiently to be all left behind. It occasionally happens that the specific gravity of the urine and of the casts is so nearly the same, that the latter will not subside for days, and in that time alkaline decomposition has perhaps occurred, which loads the sediment with phosphates and vibriones, and so renders the discovery of casts very difficult, if not impossible. These negative results then must be received with hesitation when albuminous urine and the symptoms furnish the means of diagnosis. The instances in which these casts were not found were as follows:—Two were cases of acute albuminuria, and both, as far as is known, recovered; six had confirmed Bright's disease, and died of it; one has Bright's disease, but still survives; and of five, the subsequent history is not known.

Regarding the *absence of albumen, and the presence of casts.* This is to be looked for chiefly when the kidney is contracted; but it is well known that in the other variety, albumen often disappears in the course of the treatment to appear again at a later period. Whether in such cases the casts are still recognisable I cannot now say. I have neglected to make notes on that point, and am not willing to trust to memory alone in the attempt to establish a rule. Regarding the twenty cases referred to above, they were instances in which albumen had not, so far as is known, existed at any time. In most of them the examination was repeated many times, and the patients kept under observation for months, some of them for years. In a few a little albumen could sometimes be found, oftener in the last weeks of life. The casts were, in all, either of the hyaline or granular variety, though in some they were coarsely granular. As bearing on the question raised in the earlier part of this discussion, whether such casts under such circumstances are an indication of Bright's disease, I will state all that I know relating to the subsequent history of these cases.

Observed during the last five months, none yet showing any unequivocal signs of Bright's disease, 5

Observed in the last four years, all dead, all giving evidence of Bright's disease before death, diagnosis confirmed by autopsy in two only, 8

Observed in 1838, April and May, paraplegia and cystitis, recovered, but has died within a short time, it is said of spinal disease, not seen by me since Aug. 1858, 1

Occurred with acute mania, two, and two and a half years ago, albumen disappeared with that disease, both now in ordinary health, 2

Noticed three and a half years ago with periodical neuralgia, no other sign of Bright's disease since, 1

Noticed in January, 1858, both having oxaluria, and one moderate heart disease, no other sign of Bright's disease since, 2

Noticed in April, 1859, paraplegia, no other signs of Bright's disease since, 1

Here there are six instances in which casts, hyaline and granular (finely granular), three with nuclei attached, have been noticed, and in a period of two to four years afterwards no other sign of kidney disorganization has appeared, while in eight other persons, presenting at first the same indication, and as far as relates to the urine nothing else, Bright's disease existed and proved fatal in the same period. But it is proper to add that among the fatal cases three had disease of the heart, and two had cirrhosis at the time the examination of the urine was first made.

The *sedimentary matters* found in albuminous urine, beside the casts, are very variable, and with two or three exceptions seem to be of but little importance. Blood was found nineteen times; kidney cells, mostly fatty, a few granular, fourteen times; pus usually in small quantity, forty-six times, in males thirty-four, and in females fourteen; nuclei of the kidney cells, healthy or granular, often. These have their significance. The less important matters were, oxalate of lime in 26; spores of penicillium glaucum in 24 (often this and the oxalate of lime concurring); uric acid in 20; urate of ammonia, amorphous, in 13; vaginal epithelium from nearly all the adult female patients; mucus, very commonly; healthy or effete bladder cells, often; organic globules, large or small, pretty frequently; columnar epithelium, tube casts of oxalate of lime, and sarcinæ, each once. The urine was acid in all the specimens, except one, and that contained casts, phosphates, and pus, from paraplegia and cystitis.

Hæmatoidine was found in forty-eight of these cases, usually in scales, a few times only in granules, often very abundant. I have been led to attach some importance to the presence of this substance, as an indication of congestive action. It is often produced by other diseases of the kidney, or may originate in the bladder, but its occurrence in nearly half the cases of Bright's disease is worthy of notice.

The usual tests of albumen, heat and nitric acid, have not been absolutely uniform in their action. It often happens that in alkaline urine, heat will not precipitate the albumen, but when the secretion is acid, we rely on it with confidence. Mrs. J. had disease of the heart, pleurisy with serous effusion, and extensive anasarca. Her urine was often examined and always contained casts and albumen, manifest to the usual tests, except on one occasion; then, although it was acid as usual, it was perfectly transparent after it had been boiled, and equally so after the addition of nitric acid, until it had stood a long time; at length albumen appeared in a very copious precipitate in that treated by nitric acid. After that it behaved again as albuminous urine usually does. The urine of Mr. A. F. (having cardiac disease) was examined Sept. 22d, and gave decided reaction both to heat and nitric acid. It also contained casts with nuclei attached. On the 30th it still contained casts, hyaline and granular, and was acid; but neither heat nor nitric acid in the cold urine could detect the least trace of albumen, but nitric acid added to the heated urine, gave decided precipitation. In several subsequent examinations the albumen was precipitated in the usual way, by both these tests. These anomalies depend doubtless on some unusual relations of the albumen, but what these unusual relations are my chemical knowledge does not enable me to explain.

Before leaving this branch of the subject, the two cases in which neither casts nor albumen could be found, require explanation. One was pregnant, several months advanced, had had heart disease for two years or more, was much swollen with œdema, had the complexion of Bright's disease. The urine was two or three times examined, with the result above stated. I did not see her during the last weeks of her life, and do not know the state of the urine in that time. The kidneys were found after death large and white. The other case was that of a gentleman who came to town to be treated for cirrhosis and died here. His kidneys were fibrous and contracted. The urine was always high-colored and scanty, as it usually is in cirrhosis. He died about the 6th of February. From the 1st of January to the 3d of February, examinations were made repeatedly and carefully, without discovering either albumen or casts. But at the latter date, the urine having diminished to about three ounces a day, casts were found in sufficient quantity. The immediate cause of his death was secondary meningitis. In stating then that in two instances of Bright's disease, the albumen and casts were both absent, I do not wish to be understood as saying that they were absent from the beginning to the end, but that they were absent for a considerable time, and at a period when a diagnosis was called for, and in fact was made, but based on the general symptoms, and was afterwards verified.

In these remarks thus far, I have not mentioned "the gouty kidney" and "the mixed kidney." The first of these denominations has been applied to the contracted kidney. We have so little of gout in this country, that I have not had many opportunities of tracing the connexion between it and Bright's disease. That the contracted kidney is occasionally met with in persons who have been subject to attacks of gout is clearly shown. That the condition of blood which produces the gout produces also the renal disease is suspected, and it may be so. Even if it is, the small kidney is commonly found, at least in this country, in persons who have never had the gout. The term "gouty kidney" has then less title to the possession of the contracted kidney than its rival "spirit kidney." I suppose the whole truth is stated by Dr. Geo. Johnson (p. 79): "When we come to examine the condition of the kidney which is found in connexion with gout, we shall see that it differs in no respect from other instances of chronic renal disease unconnected with the gouty constitution." I may be justified then in using the term only to reject it.

In the view that I am compelled to take of renal pathology, "the mixed kidney" can hardly be treated with any more courtesy. We have seen that almost all the diseased kidneys that I have described are *mixed kidneys;* that is, the articular lesion, which in its excess determines the variety in Bright's disease, is to be found in the opposite variety in greater or less degree. A single morbid condition does not occur alone, except at the very outset of the affection, and when the variety is not clearly determinable. The phrase has currency with those who hold that the varieties are so many distinct and separate forms of disease.

There is one remark more which I wish to make, and but one, before I speak of treatment. It relates to the œdema that is observed in cardiac affections. Some surprise or rather doubt has been expressed regarding the dependence of renal on cardiac disease, as I have stated it in these remarks. I shall soon quote the observations of others on this point, or rather regarding their concurrence. I wish now to say more distinctly than I have said, that dropsies which occur in diseases of the heart do not usually occur until the urine is ready to give proofs of grave changes in the kidney. I do not say that there is no such thing as cardiac dropsy, and yet, with very few exceptions, in some years, I have not failed to find the evidence of renal disease, whenever what is called cardiac anasarca has appeared.

Mr. President, I approach the last important topic in this formidable disease with hesitation and serious misgivings. The profession have wrestled with the malady now for more than a quarter of a century, and it may be pertinently asked whether they have gained any important advantages over it. In its chronic and most common form, if the affection is ever to be ranked among the curable diseases, the appropriate treatment is yet to be discovered. I often hear physicians say that they cure it uniformly. One relies on the mercurials and believes them sovereign; another has confidence in the specific virtues of chalybeates; a third believes in diuretics, and a fourth in active catharsis. But let the too confident practitioner wait a few weeks, or months it may be, and he will find that the fire he may have slackened is not extinguished. Indeed if he will faithfully study the indications of chemistry and the microscope, his hopes will not often ripen into confidence. I cannot say that no man ever cured the disease. I cannot even say that I have not assisted in its cure, for large numbers of hospital and consultation patients have been relieved and have passed out of the reach of my observation. The worst I can say, and unfortunately the best, is, that among the chronic cases which I have been able to follow to an issue, often through years, that issue has been one and invariable; I *do not know* that I have ever radically cured a case. To palliate, to prolong life, and even to render it comfortable after it has been gravely threatened; to liberate it, for a time at least, from a load of suffering that makes it worthless, this we can often do; I think we can do it in a large majority of the cases, if we see them in the earlier stages.

To overcome those influences which are causing the disorganization of the kidneys is the first great requisite for cure. These we cannot claim that we understand sufficiently to know how to oppose them successfully. The changed condition of the kidneys is the great pathological fact; this we cannot remedy till we can remove its cause. The uræmia is the great semeiological, or perhaps I shall be excused for saying semeiogenic fact. We cannot stop the production of urea in the tissues, or prevent its entrance into the blood. We cannot force the kidneys to a complete elimination of it till we can restore them to a more healthy state, and this will be equally true whatever theory we adopt of the origin of the disease. We know of no antidote for the poisonous effects of the accumulated urea; chemistry has not suggested a neutralizer. There are other avenues, it is true, through which the poison may escape in limited quantities, but these vicarious agencies in the end prove inadequate, and are always capricious and uncertain. We can, I believe, often relieve the kidneys of their congestion, and so retard or delay the fatal lesions in them. But after all, the treatment of Bright's disease, as we now prescribe it, is little more than a treatment of its symptoms and its complications.

(To be Continued.)

ON RESECTIONS IN MILITARY SURGERY,

AT A LATE OR EARLY PERIOD OF THE WOUND.

BEING REMARKS AND FACTS ON THE PROBABILITY OF A GREATER AMOUNT OF SUCCESS IN THE LATTER.

By RUFUS KING BROWNE, M.D.,

SURGEON IN CHIEF OF U. S. GEN. HOSPITAL, DEPARTMENT OF GULF.

WHOEVER has the conviction, will find sufficient facts and reason to sustain it, that the results of resection in military surgery are not equally conservative of life and limb with those in civil surgery: for in the former, nearly all the conditions and circumstances pertaining to the operation vary widely from those in the latter. In these the physiology of subjects of diseases and accidents incident to bones, is not remarkably disadvantageous or unfavorable to recovery. There is absent destruction of the tissues, shock to the system, and all the grave incidents pertaining to being shot in battle. Prior to the event, too, the privation and hardships, the conditions of a loss of health and vigor, to which the soldier is subject, have disqualified his system for the play of the ordinary force and vigor in the restorative functions required to reunite the wound.

When, too, the wound is first received, the great surface it opens to the action of the air and other exterior influences, becomes at once the nisus of a most morbid and destructive activity of the reproductive or cellular elements of the rent tissues—one *which by a continued reflex action is adverse to and vitiates the various functions.* From therefore the very moment these conditions and circumstances concur, the wounded man's health is impaired and endangered; but this is not all. He cannot take the ordinary amount of food, nor can even this be properly dissolved and appropriated to *replenish* the blood—a process itself the leading one in the nourishment of the body and the normal continuance of the functions.

Moreover, with this decrease of the sum of the functions, a *slackening* of the forces of life—the suppurative process continues unabated. He lies in a hospital crowded with others in the same condition, while the therapeutical means of his recovery are necessarily not the best the resources of science present. Combined with these circumstances is that distressing malady, the ineffectual longing for home, and the terrible foreboding and dread, which the sight of frequent death in his presence causes.

But these circumstances are all absent in the case of the civilian subjected to the same operation. It is done with the greatest care and circumspection, lest it fail, and the reputation of the surgeon be impaired. In civil life, the diseases of the resectable bones, if unbroken, are generally not such as really impair the system; and in case they are broken, the wound, if any, is not usually extensive. The soft tissues are not rent and lacerated as with a destructive projectile. The wound of operation is immediately cared for, and the patient when operated on is in charge of attentive friends and surgeons anxious to all the conditions of his welfare. If it is an operation in case of disease, the soft tissues while freshly cut are brought into apposition and if it is a case of compound or comminuted fracture, with a small external wound, this is equally the case.

Such is the difference between the one and the other—a difference wide enough to sustain us in our previously expressed conviction, without mention of the general disturbance of anatomical attachment of the soft tissues to the bone by the crashing power of the ball, or the liability of the soldier to purulent infection in the hospital, both of which are, however, paramount disadvantages, from which the civil subject of resection is exempt.

But we are fully experienced in a considerable number of cases of resection of wounded bones, which led to and sustain the conviction we present. So far as we know, the largest number of resections done on wounded soldiers, in any one hospital practice, were those done at the General Hospital, Fortress Monroe. Up to the month of July, we knew of fifteen cases, seven of which we were witness to, and all but one of which we were perfectly familiar with the circumstances and results of. Of these, eleven were resections of the continuity or contiguity of the humerus, and four of the middle and upper half of the shaft of the femur. Add to these five cases performed by myself on the wounded at the battle of Baton Rouge, four of which were of the head and neck of the humerus, and one of the head and neck of the femur. Of these twenty cases four only finally recovered. None of those of the femur did so, though one was still alive when I last left the General Hospital on the third of July. Of the fifteen operations, all were done well—perhaps admirably. All of my own were done without any of the proper peculiar instruments for the operation, and were therefore imperfectly, and perhaps less expertly done than the others. One of these survived, and has so far recovered as to show that he will undoubtedly have a good arm. The first fifteen operations were done at varying periods after the receipt of the wound—that is, from a week to three weeks after suppuration had been established. Not more than four of these did favorably continuously from the day of the operation.

Of the five cases, the operation was done on the third and fifth days after the wounding, after suppuration was fully established. The successful case was the first operated upon. The operation was the single straight incision. The others were all the U incision. The former I consider the most advantageous, and there are various reasons for uniformly preferring it to any other form in resection of the head or shaft of the humerus. All the resections of the humerus in the fifteen cases were by flap incisions—some V and some U-shaped. The treatment in all these cases was the supporting bandage, kept wet, with iron and other tonics internally.

Seeing that the results of the cases vary so greatly from the well known large proportion of successes in resection of the same bones in civil practice, the question presents itself—Would there not be a larger proportion of successes in the former, if the operation were done while the wound is fresh or very recent? Undoubtedly where there is extensive comminution of the wound, permitting the fragments of bone to remain, increasing the amount and extent of the suppuration, we do not know what the result of an immediate resection would be. Hitherto the practice of military surgery was always to postpone for a greater or less period, operative procedure in those cases, and this for the reason that the surgeon, not considering this class of cases as requiring it at once, and not finding it *easy* to ascertain the exact extent of the wounds of the bone, left them to be *determined by time.* But this must be an inferior, if not mistaken practice, and one adverse to all accredited rules of ordinary therapeutics, which is to *do* the best *at the time* of the difficulty. It is to leave surgical interference undone, and its doing to *turn* upon the very morbid and destructive process, consecutive to wounds, which surgical interference should be the very first to avert and prevent or lessen. Perhaps this discrepancy is accounted for by the absence of any positive rules, deduced from sufficient experience, of the results of immediate resection in military surgery; and the same practice would be the case in amputations were we without rules, likewise so deduced from sufficient experience in them, for the guidance of the surgeon. But such rules for the moment of resection in the comminution of bones by gunshot wounds in soldiers, it should be our first business to settle while the opportunity lasts. Of course the case *is* as it at present stands, because in surgery as in all other branches of science, the order of departure or advancement from the doubtful is, by sufficient experience, to the positive.

In military *amputations* such rules are more or less established, and many of the reasons upon which they are sustained for *immediate* amputation, are equally forcible for immediate resection. Where the continuity of a bone is broken, or comminuted, or crushed, the amount of morbid irritation is remarkable—it cannot be exceeded—and can only be allayed by the total removal of the offending

bodies. Certainly surgeons are directed by written authorities to remove all detached fragments of bone, on the first examination; but this is very rarely more than partly done, and seldom done at all, except of minute pieces, or others which come away with but little traction on the forceps, and without requiring further detachment. I am experienced in a considerable number, perhaps many cases, where I, not being in charge of the wounded patients, pleaded for a free incisive exploration, to ascertain and to extract all the pieces completely broken from the larger remaining parts of the shaft, but it was denied. Sometimes, in cases where the suppurative and sloughing action, which they in part caused, had been established many days without abatement or sign of improvement. If at this period of the wound, however, the surgeon, up to this moment, constant to the practice of waiting, perform resection, the tissues involved can neither take part in a reparative process, nor become a part of what is saved by resection. The system itself is at the lowest grade of vigor, and in the very poorest condition to sustain the operation, besides the special infirmity consequent on the continued suppuration of the first wound. I have witnessed several such cases in which the operation at this period was followed by gangrene, and required the second operation of amputation. And it is precisely here we see the paramount disadvantages which constitute the grave difference between the civil and the military view of resection—*a difference which may be sufficient to account for the great disparity in the results of resections* in the two so far as I present them. The first, in the majority of cases, prior to the period of the operation, undergoes none of this long suppurative stage, and it was this which led me to suppose that resections in military surgery while the wound is still fresh, if well done, would turn out much more conservative than our record of cases proves. Moreover, it has always seemed to me, that where the large or larger parts of the shaft of the bone, remaining consolidated with its soft tissue, is disconnected by a complete break from a smaller piece, whether between the two there is obvious displacement or not, the latter should be removed, for it can be explained, in disproof of any objection to this, that the physiological condition of a broken bone, with this line of demarkation, at the other end of which there is an *absence* of the fragments carried away, is very different from that of a bone accidentally fractured, where, however complete, the fracture there is no *loss* of part or parts of the bone; and conversely, it seems to me that where the larger part of the shaft of the bone consolidated with its tissues, at the end where the *loss* exists, was broken off obliquely, or so as to present a large portion of its spongy portion, this need not in resection be sawed off up to a point where the natural diameter is complete, but simply rounded off.

(*To be Continued.*)

Reports of Societies.

NEW YORK ACADEMY OF MEDICINE.

STATED MEETING, June 18, 1862.

DR. JAMES ANDERSON, PRESIDENT, IN THE CHAIR.

DISCUSSION OF DR. BYRNE'S PAPER ON PELVIC HÆMATOCELE.

(*Continued from page 260.*)

DR. BARKER—By the term pelvic hæmatocele is meant precisely the same as that affection styled by Simpson hæmatoma, or an extravasation of blood in the pelvic cavity. The French authors have divided it into two forms—the intra-peritoneal hæmatocele, where the blood is extravasated between the wall of the uterus and the peritoneal covering, and extra-peritoneal effusion, where the infiltration of blood takes place in the cellular tissue behind the peritoneal cavity, and between the uterus and the rectum.

A great deal of discussion has taken place among the French authors as to the comparative frequency and rarity of these two forms, as to the comparative danger, and as to the comparative treatment of each. No man has ever seen a large number of cases, and hence no great deductions can be drawn from the experience of any single individual.

Now I do not propose this evening to go over the whole ground of pelvic hæmatocele, but, taking the paper of Dr. Byrne and the case which has just been read as a basis for my remark, to discuss a few points relative to its pathology, semeiology, and treatment.

As I have such a high appreciation of the paper of Dr. Byrne, I shall not hesitate to criticise it where I differ from the author. In one respect it strikes me the author is quite wrong. He regards the disease as due in a large proportion of instances to antecedent ovarian inflammation. In the course of the essay he quotes from Tilt, Ashwell, and others, who are disposed to consider ovarian inflammation very frequent, and very often the cause of pelvic hæmatocele, and I do not think I use too strong an expression when I say that he sneers at the views of Henry Bennet upon the subject, who regards ovaritis as a very rare disease. Now, I think, the difference between Henry Bennet on the one hand, and West, Ashwell, and others on the other hand, is this—Bennet writes from a careful study of the disease as it appears to him at the bedside, and not from the study of authors, or from any preconceived theories. The more enlarged my experience becomes, the more I am convinced of the truthfulness and accurateness of Bennet. I do not agree with him in everything that he says, but in most respects I find reason to accept his views. In my own observation acute inflammation of the ovaries unassociated with parturition is one of the most rare affections ever met with. I doubt very much if I have ever seen a clear well marked case, and I have been for years looking for its existence in the dead-house. I do not mean to say that it does not, or that it cannot exist; but I do say that it is of very rare occurrence. Tilt describes subacute ovaritis, and let any young medical man or medical student read his book, and he will be disposed to think that subacute ovaritis unassociated with the puerperal state is one of the most common of female diseases. In the puerperal state we may often meet this disease, but I am speaking of it unconnected with such a cause. Now, my reasons for believing that Dr. Tilt, and all the authors that have accepted his views, are wrong on this point, are these: that in very many of those cases I have seen those very symptoms which he describes as characteristic of subacute ovaritis associated with diseases of the uterus, especially of the cervix, and entirely disappear by the cure of the local lesion. But I go still further than this; I have developed that class of phenomena which Dr. Tilt considered as characterizing ovaritis by my treatment of the diseases of the cervix uteri, that is to say, in patients who have induration, etc., of the cervix requiring local applications, and where, previous to these applications, none of those symptoms referable to the ovary had existed. I have produced the symptoms to that extent that if we accept the description of that disease one would be ready to believe that ovaritis actually existed. These symptoms have all disappeared when the disease of the cervix disappeared, and when the applications were discontinued. So then I regard all these symptoms which have been characterized as belonging to subacute ovaritis in the same light as the surgeon regards the irritable testis and irritable mamma—a special form of neuralgia, if you please. It is not the definition that I should use, though I am not aware that the surgeons have told us precisely what this condition is. I consider then these symptoms of ovaritis as secondary to disease of the uterus in the vast majority of cases.

Therefore I cannot agree with Dr. Byrne in the belief that pelvic hæmatocele is almost invariably secondary to this disease of the ovary. But it is found that pelvic hæmatocele is developed in a large proportion of cases immediately in connexion with the function of menstruation; in the very large proportion of cases in connexion with the physiological congestion of the uterus and appendages. In

some rare cases it follows abortion, but it is not, properly speaking, a disease of parturition. I have studied all the reported cases very carefully, and it seems to me that that must have been a mistake in the diagnosis in relation to its connexion with parturition; I think a careful analysis of the symptoms would show this to be so. There is one reason why hæmatocele should not follow parturition, for profuse discharge of blood from the internal surface of the uterus, by emptying the vessels, would be a prophylactic of hæmatocele. It has been supposed that hæmatocele occurred from a rupture from the vessels of the ovary, that we had hæmorrhage resulting from them, and that hæmatocele was an extravasation following this. The ovary is not an excessively vascular organ, it does not possess vessels enough to give off from eight ounces to two or three pounds of blood. There are some cases of ovarian apoplexy, where blood finds its way into the tissue of the organ; we see ovarian clots in the dead-house often enough, but this is entirely distinct from hæmatocele. Although hæmatocele usually comes on immediately after menstruation, I think it due to a rupture of the vessels entirely distinct from those of the ovary. In many of the cases where an autopsy has been made the utero-ovarian vessels were found in a varicose state; in some cases where the examination has been made, it is found that there was an aneurismal enlargement of the vessels, and in a certain case, the one reported by Tilt, there was found an aneurism of the small branch of the internal iliac. But I think this is to be regarded as something different from what we are dis ussing.

But while I do not accept acute inflammation of the ovary as a special predisposing cause of this disease, I do think it results from some exciting active causes which produce sudden congestion and rupture of some of the vessels connected with the uterine organ or its appendages. This may be, as in some instances, a rupture resulting for instance from occlusion of the uterus, so that there is a reflux of blood from the uterine cavity at the time of menstruation through the Fallopian tubes and fimbriated extremity, and the blood is discharged there. In a few instances the autopsy has shown this to be the explanation. In other cases the cause seems to be double. The organ becomes very much congested, an accumulation takes place in the Fallopian tubes, until one of them, distended by the formation of a clot, produces a rupture of its tissue, the blood is then gradually discharged into its nisus, either intra or sub-peritoneal, and the gradual accumulation of the clot separates it off until a large amount of effusion takes place there.

Now another point is as to the diagnosis of this disease. In the first place, the symptoms of hæmatocele come on suddenly; they occur from some exciting cause, and are produced suddenly. With all due respect to the judgment of the author, I cannot consider his first case as one of pelvic hæmatocele. If we judge it by his tests, by the symptoms he has detailed on page 13, I think the conclusion must be that it is a case of pelvic cellulitis. Now the diseases which it is necessary to distinguish from pelvic hæmatocele or which may be mistaken for pelvic hæmatocele, are in the first place pelvic cellulitis, or inflammation of the areolar tissue of the pelvic cavity. This is distinguished from pelvic hæmatocele by the following:—Cellulitis is ushered in by chills, followed by fever. It is accompanied by intense pain at the point where the effusion takes place, and forms a tumor in the pelvic cavity which is exquisitely tender and non-elastic; that is, in the first stage, but subsequently when the process of suppuration goes on, we get a distinct mark of *fluctuation*. Now all this is a process of some days' duration, during which the patient has all these symptoms which characterize acute inflammation, and subsequently those which characterize the formation of pus. But the symptoms which characterize pelvic hæmatocele are ushered in with great rapidity, and they are symptoms which do not express or represent inflammation, but hæmorrhage. There are evidences of excessive prostration—pallor, a very small and feeble pulse, and subsequently anæmia. Most generally, I have seen that it has been followed by symptoms of intense local peritonitis. The patient complains of most severe and intense pain in the pelvic region, but not the exquisite local tenderness of cellulitis. When we have a tumor resulting from inflammation of the areolar tissue of the pelvic cavity, it is exquisitely sensitive and non-elastic until we get suppuration and a distinct fluctuation, but no tenderness of the abdomen, unless it is associated with peritoneal inflammation. The tenderness on examination of this tumor is tolerable, not at all in proportion to the exquisite sensitiveness of pelvic cellulitis. This patient would allow the tumor to be raised up. Introducing my finger into the rectum, I could lift up the tumor, I could carry it forward somewhat without causing any great appearance of distress, which would not be possible in pelvic cellulitis.

I need not stop to discuss the diagnosis between pelvic hæmatocele and retroversion. It is said to have been mistaken for it. Without stopping to discuss the various symptoms of retroversion I will mention one sign which will serve to guard against any possible error—the use of the sound. If by this instrument we find the axis in its normal relation, this, exclusive of all other signs, will determine the distinction between hæmatocele and retroversion. A superficial examination might lead one to suppose retroversion to exist, because some of its symptoms are like those which usher in pelvic hæmatocele, for the patient has great difficulty for two or three days in micturition and frequent evacuations, but these are not associated with symptoms of peritoneal inflammation.

Dr. Byrne in his paper alludes to the possibility of mistaking this disease for dislocated tumors, fibrous tumors, and extra-uterine fœtation, but I think the antecedent history and the want of the explosion of symptoms will be sufficient to make the diagnosis very clear. I have recently seen a case of cancerous disease in the pelvis which, in its physical signs, resembles hæmatocele. This is not included as being a pathological condition which might possibly be mistaken for that disease. I have seen but three cases of carcinoma of the colloid form in the pelvic cavity. Of these three cases two died very rapidly within two months. The last case I have seen in consultation with Dr. Buck and Dr. Linsly, where the symptoms commenced six weeks since. In that case there is a soft elastic tumor not connected anteriorly with the uterus, but connected posteriorly to the organ and laterally. The sensation of examining the tumor was very like the sensation given by pelvic hæmatocele, but the patient is some fifty-four or fifty-five years of age, and no case of hæmatocele as yet has been reported, that I have seen, when the patient has passed through menstrual life, except in the instance alluded to—rupture of an aneurism, which should rather be considered a surgical lesion. Then again the development of the disease is not by the explosion of the symptoms of collapse and anæmia followed by intense peritoneal inflammation, but it has been accomplished throughout without pain but with marked cancerous cachexia.

As to some of the exciting causes, I have already spoken of menstruation as being the predisposing, as most of the cases have occurred in connexion with the catamenial period. Of the exciting causes excessive coition has been mentioned as one, excessive shock or cold, injuries, falls, or miscarriages, or excessive constipation. For instance, this patient, whose case is reported to-night, says that she had a miscarriage at two weeks. She had gone two weeks over her usual catamenial period, and she believed she had miscarriage, because a substance somewhat like a fleshy piece escaped from the vagina unattended with pain. When the symptoms came on, she was moving. After very careful questioning, I believe she had no miscarriage at all, and that the substance was probably a coagulum which passed from the uterus at the time the effusion took place; but still this cannot be definitely determined.

In a patient whom I saw in her first confinement, and

who afterwards moved to Astoria, and who suffered some time from chronic metritis, this explosion of symptoms belonging to hæmatocele took place. She was at the time under the care of my friend Dr. Trask, and I need not say to any who have read his papers, that he is a most careful investigator and one of the best analytical minds in the profession. He had never seen a case of hæmatocele, and is disposed to doubt whether there is one. This patient was taken, after using an injection of cold water, with symptoms of intense pain of the peritoneum, followed by great tympanitis, and by profuse hæmorrhage from the uterus. By profuse I mean a sudden discharge, although the aggregate amount was not great; but it was followed by excessive collapse, so that for days, and I visited the case sometimes twice a day, it was doubtful whether she could live from one hour to another. There was great difficulty in evacuating her bowels, and her bladder was in a condition to require the use of the catheter. Peritonitis was quite intense, and a tumor was developed behind the pelvic cavity which lasted many months, when pus formed and discharged. Dr. Trask from this circumstance was disposed to think that we had an abscess of the posterior wall of the uterus. In reference to this disease, I need not say that, unassociated with parturition, it is even more rare than ovaritis.

Another case which came under my observation, occurred in a young lady, nineteen years of age. She went to a ball just as menstruation was commencing, and danced nearly all the night. Residing only two and a half blocks from the place of the ball, she walked home in thin slippers, at a very late hour in the night or a very early hour in the morning. Abont five o'clock the same morning she was taken with intense pain and prostration following some discharge of blood from the uterus. Death occurred on the third day. I saw her in consultation on the second day, when the existence of an elastic tumor behind the uterus was clearly made out, and the concurrent symptoms left no doubt in my mind as to the nature of the case.

Another case which I visited was in consultation with a gentleman I see present. The patient was married first at the age of eighteen, and a year after her husband died of phthisis. At the age of twenty-three she married a second time, and the third night after she was taken with the symptoms of a profuse discharge of blood. In this case, in which there was excessive prostration, nausea, faintness, and vomiting, which kept up for several days with coldness of the surface, very rapid and feeble pulse, and intense abdominal pain, there was a large tumor formed in the pelvic cavity, and after she had been under observation for several months she was eventually cured.

(To be Continued.)

NEW YORK COUNTY MEDICAL SOCIETY.

ALFRED UNDERHILL, M.D., PRESIDENT.

Reported by Guido Furman, M.D., Secretary.

A Stated Meeting of this society was held on Monday evening, the 3d instant, at the College of Physicians and Surgeons. The meeting was an interesting one, and well attended. Prior to commencing business, Dr. Alfred Underhill, the newly elected President, delivered the following inaugural address:—

Gentlemen of the New York County Medical Society:—Having been elected your presiding officer for the ensuing year, you will credit me when I say that I have not the vanity to think this manifestation of respect emanates from any special merit of my own, for a position once held by so many distinguished gentlemen who have preceded me, such as Romayne, its first president, as Hosack, Beck, Johnston, and others, of the highest grade in our profession, but as being wholly complimentary on your part; you will therefore allow me to express to you my sincere thanks for the honor conferred upon me. And at the same time, gentlemen, I would congratulate you upon the measured success which has already followed your efforts of the last two years to resuscitate this society from a state of desuetude and feebleness of several years' duration, to that of activity and usefulness.

The New York County Medical Society is one of the old institutions of New York; it has had an existence of more than half a century, during which long period its history has been, like everything of human invention, of varied and chequered fortune; sometimes all buoyant with successful effort; sometimes struggling for its very existance, as in these latter days, when in the fostering hands of your retiring president it has been warmed into life again, and is, we trust, still to go on increasing in reputation until it shall compare favorably with any period of its brightest prosperity.

In the earliest act of incorporation by the legislature we find it stated that, among other objects to be attained besides the regulating the practice of Physic and Surgery, was the contributing to and disseminating the knowledge of the healing art. At this day, societies for various purposes exist in large numbers in every direction and in every land; the principle of association or combination of individuals for mutual advantage, common to them all, is not of modern origin, but may be traced back for many centuries; it now, however, has a more general adaptation to the wants of mankind than at any former period, it is adopted in all civilized communities, and in almost every pursuit of life; we see this exemplified in banking institutions and other corporations, in trade and commerce, in benevolent societies, and in institutions of learning. Upon this principle of association, which has been found so potent for good to masses of men, this society was established, and, without doubt, if its members had continued to give to its legitimate claims a fair degree of their efforts, in place of making it an arena for cliqueism, for violent debate and invective, and, indeed, for almost all purposes than that of medicine proper, causing a large majority of its members to shun its halls, and even an aversion to its very name—it would have escaped that long sleep of suspended animation from which it has just awakened, and at this day have been honored as the first in character and influence in our city in medical and surgical science.

But now the thick mists and clouds which have so long enveloped it are passing away, and we have fairly entered upon what we may hope is a new epoch in its history; and although its meetings are attended by a limited number of its long list of members, the greater part of whom have become interested in other kindred associations, there are those among us who will labor and study for its interest and success.

The present time is one of fearful and momentous concern, both to our whole country and to ourselves as medical men—a time when all the power of this government is brought into the most active operation to put down a rebellion unexampled in the history of the world—when immense armies, such as have been never before gathered, are fighting to save intact our beloved Union—when our own profession have gone forth nobly with our bravest and best at the call of their country, willing to take their chance of danger, either in the camp or in the hospital, upon the ensanguined battle-field or in the deadly marshes of a Chickahominy, to exert its saving skill upon all that the miasm, the sword, or the cannon may have spared. And, to the everlasting honor of the government be it said, they *have made no compact with quackery* in any of its forms, for they have received none but the regular and properly qualified into the national service. We say, then, in a time like the present, when anxiety, fear, and terror, by night and by day, are the portion of thousands of swelling bosoms in our land, it well becomes us, who are secure in our pursuits, to be diligent and untiring in our efforts to improve our science, that all may be mutually benefited and go forth better armed for the responsible duties we are called upon to perform.

For the accomplishment of these objects it is confidently hoped that our members generally will present to the society an offering, be it great or small, which will accu-

mulate in a common fund of medical knowledge for the good of all, being well assured that every jewel added to its crown will reflect its lustre back again upon themselves. It is likewise expected that we shall have a paper read at each stated meeting eliciting discussion; that the reports of the several committees will be regularly made, and that cases of interest will be related, calling forth the remarks and experience of members. With proceedings of this character faithfully carried out, it is believed our meetings will be of such interest that they will command a regular and large attendance. It now rests with yourselves, gentlemen, how far this work may prosper; and succeed it will, we doubt not, for we are rapidly adding to our working numbers, both the young and ardent, and also the tried and honored of our profession.

American Medical Times.

SATURDAY, NOVEMBER 15, 1862.

THE PROSPECT OF HEALTH-REFORM IN NEW YORK.

The friends of improvement in the health-regulations of our city are again asking the question, "What are the prospects of sanitary reform in New York?" It is not to be denied that they are most discouraging. The defeat of the health bill last year, through the defection of one of its former friends and advocates, and that at a moment when the long contest was about to be decided in its favor, was perfectly disheartening. This ungenerous and unpatriotic act of a high official, whose alliance with a corrupt and mercenary opposition at the last moment was not contemplated, unnerved the stoutest heart. Many have been led to believe that all subsequent efforts would, in a similar manner, prove abortive, and have counselled an indefinite abandonment of all measures for obtaining the requisite legislation until some fortuitous circumstance should give us an incorruptible legislature.

Meantime, thousands of our citizens are annually dying from diseases which this reform would remove; our streets are reeking the live-long year with accumulating and unremoved filth; the poor and laboring people live in underground rooms, never cheered by the sun's rays, or in tenement houses, uninhabitable except by human beings who have never known what it was to breathe fresh air. Quarantine, managed for the pecuniary benefit of the few, is become a formidable obstruction to commerce, but a ready method of introducing epidemic diseases directly to the city. Disease of every form and variety stalks abroad, unchecked and unrestrained by the ignorant and corrupt officials who disgrace the health department. In every respect the need of sanitary reform is more pressing and more apparent. And yet, at this critical period, we find many disposed to yield the struggle, and cease all agitation of the subject, at least for the present.

We should not, however, lose sight of the fact that we are striving to accomplish a reform which in importance and in magnitude rises superior to all civil, social, religious, or political questions of the times. It aims to incorporate the higher elements of a Christian civilization in the administration of our civil affairs. Fully developed, and exercising their influence without restraint, the reformatory measures to which they seek to give the binding force of legislative enactments, become of vast consequence to the State. This is true in a threefold sense. First, they will greatly lengthen the average of human life by protecting the citizen, and especially the laboring classes, from the local causes of disease. Sanitary science directing municipal authority, with one hand vigilantly guards the approaches of foreign pestilence, and with the other carefully removes from the domicil every source of endemic disease. In many cities in the old world, and in some in the new, this fact is strikingly demonstrated. The average of human life has been lengthened in Paris, in London, in Liverpool, and other populous towns where stringent health regulations have been efficiently carried out. Second, these health reforms tend to develop a strong and healthy generation of citizens. They provide well ventilated dwellings, they remove all local influences which debilitate and deteriorate, or which stifle the growth of the young, finally they protect the unsuspecting against adulterated and improper foods and drinks. Thirdly, All health reformers add largely to the sum of human happiness. They make happy homes, and from this springs that greatest of all public virtues, domestic contentment. In this estimate we should take into consideration the innumerable blessings, social, civil, and religious, which flow from a home where ruddy health glows upon every cheek. The cheerful and social family circle adds to the community citizens having correct and intelligent views of their civil and religious obligations, with a conscientious determination to fulfil them.

We have recalled these more prominent points in health reform, believing that too often its friends are inclined to regard it as a mere political question, which is to be urged forward or abandoned according to the political complexion of the State Government. It should be placed on a higher footing. It appeals for support alike to all classes and conditions of society, and every member of the community should be made to feel an individual interest in the success of a measure which brings good to the most humble as well as the most exalted. The work of sanitary reform, like all great public improvements, has this disadvantage. It must be undertaken as an enterprise, the benefits of which are first to be experienced before they can become popular. But its advocates have this encouragement, that it is a reform that never takes a retrograde step. Whatever is secured in the enlightenment of the people, or in the inauguration of positive legal enactments, is never lost.

We are not advised as to the course which the friends of the health bill will pursue during the approaching session of the Legislature. We trust it will be pressed upon the attention of our State Government with as much vigor as in former years. In no other way can we retain the influence which was gradually accumulated in its favor through years of discussion. The public mind is now very well informed of its principles, and a firm conviction of its necessity is now widespread, both in this city and throughout the State. That conviction is the result of agitation, and agitation should not for a moment be intermitted. Much is lost by the long interval of silence between the sessions of the Legislature. All might be lost that has been gained if a whole year should elapse without any agitation of the subject. It is true that we are liable to disappointment while the Senate contains such members as Abbott, Truman, and Robertson, and while the Mayoralty of the city is filled by an Oppyke, but this fact does not change the nature of our

obligations to the public. Fully impressed with the importance of sanitary reform, we are bound to urge it forward at all times or by every means in our power. If the prospect of success is not so great as last year we ought to put forth increased energy instead of relaxing our efforts.

THE WEEK.

The danger of allowing persons who exhibit mental aberration to go unrestrained in households, is frequently exemplified in the occurrence of fearful crimes. Several cases have recently been reported of the wholesale murder of children by parents, and on judicial investigation the murderer has been found to have exhibited symptoms of insanity previously to the deed. During the past week a case of suicide was published in the city papers, which illustrates the same fact. It appears that the criminal, a young man of previous good character and habits, had been heard by several members of his family to remark that the time had come for him to die. No serious importance, however, was attached to the remark, until the Friday afternoon preceding his death, at which time his conduct became so wild and strange, that his friends became suspicious that he was not in his right mind. He kept continually repeating the remark that his hour had come, and took leave of his friends. He then proceeded to an adjoining room, procured a razor in spite of the efforts of his mother to prevent him, and cut his throat so effectually as to cause almost instant death. These frequent and fearful tragedies, performed by unrecognised lunatics, deserve more consideration than is given to them by a Coroner's jury. The community should be awakened to the fact that mental aberration, however slight, requires even more prompt attention from the physician than the diseases of any given organ of the body. A contemporary adds:—"Let the public learn to look upon lunacy as a disease to which they are as much exposed as to maladies of the lungs, of the heart, or the bowels; let them learn to apply to a physician when they observe strange alterations in the ordinary mental functions of an individual, as readily as they seek his help for changes experienced in the bodily functions; and we shall presently see a diminution of those sad, those horrible murders, which are the direct result of a *diseased mind—of lunacy.*"

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The non-appearance of yellow fever at New Orleans, and its appearance in other Southern cities, would seem to prove the value of cleanliness in the prevention of this epidemic. In the management of the civil affairs of that city, Gen. Butler has enforced cleanliness and quarantine with a rigor never known in any city on this continent. In contrast with New Orleans we may place Port Royal, S. C. Yellow fever has appeared recently at this point, and according to the reports, with the greatest virulence in the unpoliced districts. Certain portions of the town contain undrained reservoirs of sewerage, and here the disease first began its ravages. We may learn some useful facts in civic police from the arbitrary military rule which governs many Southern cities.

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The form of examination before the Army Medical Board will be found in this number. The questions will be found to take a comprehensive range of subjects in all departments of medicine, surgery, midwifery, materia medica, etc. The medical student who contemplates entering the army will now learn the scope of the examination, and prepare himself accordingly.

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The Annual Oration before the Academy of Medicine was delivered on Tuesday evening, at Dodworth's Hall, by Dr. S. C. Foster. The audience was large and select. The President, Dr. Anderson, was in the Chair, and first introduced the Rev. Dr. Vermilye, who opened the exercises with an appropriate prayer. The orator was then introduced, who discussed at length the many-sided character of the medical profession, its duties, its labors, and its rewards. The address was attentively listened to, and will soon be published by the Academy.

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The medical examinations under the draft in this City and in Brooklyn were concluded on Saturday last. The care with which Surgeon-General Vanderpoel selected the corps of examining surgeons, gave very great satisfaction to our citizens. It was frequently remarked, that a body of men so competent for a special duty was never before appointed at Albany. Every surgeon appointed served faithfully, though it required on the part of many a great sacrifice of valuable time. The statistics which have been recorded will be valuable, and we trust the Surgeon-General will, at some future day, have them collected and published.

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In another column will be found a notice of a meeting of a Naval Medical Examining Board, which is about to meet at Philadelphia, to which we invite the attention of students.

Reviews.

The Action of Medicines in the System. By Frederick William Headland, M.D., B.A., F.L.S. Fourth American Edition. Philadelphia: Lindsay and Blakiston. 1863. Pp. 448.

We gladly welcome another edition of this excellent treatise. It is by far the most useful work on therapeutics in our language, and could be studied daily by every practitioner with great advantage.

A Practical Treatise on Dental Medicine, being a Compendium of Medical Science, as connected with the Study of Dental Surgery. By Thos. E. Bond, A.M., M.D., Professor of Special Pathology and Therapeutics in the Baltimore College of Dental Surgery. Third edition, revised, corrected, and enlarged. Philadelphia: Lindsay and Blakiston. 1863. Pp. 411.

This work has proved very acceptable to the dental profession, as is proved by the issue of a third edition. It belongs, however, both in pathology and practice, to a past age, and is not such a work as we should care to place in the hands of a medical student.

Anatomy of the Arteries of the Human Body, Descriptive and Surgical, with the Descriptive Anatomy of the Heart. By John Hatch Power, M.D., Professor of Anatomy in the Royal College of Surgeons, Dublin. Authorized and adopted by the Surgeon-General of the United States Army, for use in Field and General Hospitals. Philadelphia: J. B. Lippincott & Co. 1862. Pp. 401.

This work has been republished under the authority of the

Surgeon-General of the United States Army. The design of the re-publication was to furnish the surgeons of the army and of the hospitals with a volume containing in convenient form a full description of the arteries, and the several operations upon them. The work will admirably answer the design of the publisher. It is also well adapted to the surgeon in civil practice, and to the student of operative surgery.

FORM OF EXAMINATION OF CANDIDATES FOR ASSISTANT-SURGEONS IN THE U.S. ARMY.

The following questions selected at random from those used by the Army Medical Board which was in session in Washington, in May and July last, and of which the Surgeon-General was President, exhibit the character of the examination.

Previous to the assembling of this Board, the examinations for admission into the Medical Staff of the Army were entirely oral, except that a short thesis was required of each candidate on some medical subject.

Now, the examination is entirely written, except that the candidate is examined from one to two hours on his literary and scientific qualifications, in which his knowledge of history, geography, zoology, literature, natural philosophy, ancient and modern languages, etc., etc., is thoroughly inquired into.

After this, a set of written questions on some one branch is given to him; he is furnished with writing materials, and three hours allowed him in which to give his answers. These answers are then signed and handed into the Board with the questions, and so on until he has been examined in all the branches.

A merit roll is kept, in which the result of the examination in each branch is recorded.

It will be seen from the questions submitted, that no one who is not thoroughly posted in his profession, should present himself before the Board.

SURGERY.

1. How are fractures of the femur in any position of the shaft or condyles ascertained, and how are they treated?
2. What are the symptoms and treatment of syphilitic iritis?
3. Describe the surgical anatomy of the parts involved in the operation for ligature of the femoral artery at the points usually selected for that operation?
4. Describe the surgical anatomy of the parts involved in the lateral operation for stone, and describe the operation?
5. Enumerate the coverings of inguinal and femoral hernia, and give the important anatomical relations of each?
6. Describe the operation of resection of the knee-joint, and give the causes demanding the operation?
7. Describe the varieties of cataract, causes, pathology, and treatment?
8. Describe the symptoms of fissure of the anus, and treatment?

ANATOMY.

1. Describe the origin, course, and distribution of the pneumogastric nerve?
2. Describe the carotid artery, its origin, course, relations, and branches?
3. Give the surgical anatomy of the parts concerned in the resection of the elbow-joint?
4. Give the surgical anatomy of the perineum
5. A bullet passes through the arm above the elbow, subsequently it is found that the extensor muscles of the hand are paralysed. What nerves have probably been wounded?
6. What is the minute anatomy of connective tissue?
7. What are the histological appearances of a thin transverse section of the shaft of a long bone?
8. Give the microscopical anatomy of the kidney?

PRACTICE OF MEDICINE.

1. Give the symptoms in detail of a case of confluent small-pox, terminating in recovery, with the diagnosis from measles prior to the formation of the pustules?
2. Describe briefly the symptoms and treatment of a case of remittent fever, assuming during its course a typhoid character?
3. How would you treat a case of acute pleurisy if you saw it before effusion had taken place into the thoracic cavity? How, if effusion had already taken place?
4. Mention the prominent symptoms of chronic rheumatism, with some of the remedial measures appropriate?
5. Enumerate the several organic lesions and functional disturbances which may produce diarrhœa?
6. What do you understand by Bright's disease of the kidneys?
7. Enumerate the principal causes which may produce phosphatic deposits in the urine. Give the appearances presented by such deposits to the eye and the microscope, and the treatment proper for such cases?
8. Specify the rational symptoms and physical signs by which you would discriminate between a case of chronic bronchitis and one of phthisis?

GENERAL PATHOLOGY AND PATHOLOGICAL ANATOMY.

1. What do you understand by inflammation?
2. Describe briefly the appearances of the naked eye and the microscopical anatomy of the process which terminates in the formation of pus in the subcutaneous areolar tissues?
3. Mention some of the chief causes that produce tuberculosis, and describe the appearance to the eye and microscope, of distinct yellow tubercles of the lungs?
4. Enumerate the chief morbid alterations which may actually be observed in the blood?
5. Tell what you know of the pathological anatomy and histology of the glands of Peyer.
6. What are the prominent phenomena which discriminate between sthenic and asthenic forms of disease?

PHYSIOLOGY.

1. What is the composition of the gastric juice, and what functions are assigned to it by modern physiologists?
2. What is the composition and origin of urea?—what becomes of it in chronic diseased conditions of the kidney?
3. Under what circumstances does sugar originate in the economy; what is its function, and what becomes of it?
4. What do you understand by nervous irritability? Can it be destroyed without destroying muscular irritability?
5. What are the earliest internal changes in the ovum after impregnation?
6. Describe the Graafian vesicles, and give an account of the formation of the corpus luteum.
7. What is reflex action? Enumerate some of the chief reflex actions constantly going on in the healthy adult?
8. What is the general arrangement of the nervous system of articulata?

OBSTETRICS.

1. About what time were forceps introduced into the practice of modern midwifery? Name some varieties and describe the difference.
2. What are the indications for the use of the forceps, and how are they to be applied?
3. How many varieties of puerperal convulsions are usually treated of? Name them, and give the appropriate treatment in each case.
4. Give diagnosis of breech presentation, and state the comparative number of vertex and breech presentations.
5. What is meant by Dystocia? Enumerate some of the causes.

6. How many positions of vertex presentation do you admit, and how many of the breech?

7. How does a face presentation differ from a vertex, and can it be changed? If so, how and when?

8. What is the technical term for milk leg? Give its pathology.

MEDICAL JURISPRUDENCE AND TOXICOLOGY.

1. Describe the symptoms of poisoning by acro-narcotics. The remedies to be employed in cases of such poisoning.

2. Describe the tests for corrosive sublimate, with its antidote.

3. What means would you employ to distinguish whether the stains on a sword were blood stains or ordinary rust?

4. What are the antidotes to be administered in cases of poisoning by the mineral acids?

5. In case a person should be found dead in bed, what steps would you take to ascertain the cause of death?

6. What are the symptoms of poisoning by oxalic acid? The treatment?

MATERIA MEDICA.

1. When was Quinine discovered? how is it obtained? in what form is it used in medicine? State its chemical composition. What the sources of supply (commercially), and what adulterations have been found, and what substitutes for it have been proposed?

2. Do all cathartic medicines act alike? If so, how? If not, state the differences.

3. How many preparations of arsenic are in general use in the practice of medicine? Give the officinal names and chemical composition of each.

4. What is Alcohol? What are the methods of obtaining it? What is the strength of officinal alcohol?

5. State the varieties of opium found in the markets, their commercial history, physical differences, the method of obtaining the best quality for medicinal use.

6. What is chloroform? When was it discovered and by whom? How is it made, and when was it introduced into the practice of medicine?

7. Write out in full, or abbreviated, a compound prescription for the apothecary, for putting up a powder, a mixture, a solution, and also for pills, giving the usual apothecary's signs, and the directions for taking the doses of each.

CHEMISTRY.

1. Give the chemical history of nitrogen, and of its compounds with oxygen and hydrogen. Describe the mode of manufacture of nitric acid.

2. Describe the oxyhydrogen blowpipe, and the uses to which it is applied.

3. What are the Haloid salts? Name some of them.

4. What is Iodoform? How is it made?

5. Describe sodium. Give the detailed history of its oxide and of the compounds formed by it. Write the officinal names and give the chemical formulæ of all compounds of it used in medicine.

6. Can oxalic acid be made artificially? If so, by what process? Write the formula of oxalic acid.

HYGIENE.

1. Is the mouth or source of a river the more healthy, and which point would you select for the location of a camp or hospital, and why?

2. What are the effects of having too many men crowded together in a hospital? State fully the nature of the evils and their mode of action.

3. What means would you use for warming, lighting, and ventilating hospitals and barracks?

4. Name several of the principal disinfectants and their mode of action.

5. How would you estimate the amount of water required for washing, cooking, and for the water closets of a hospital for five hundred men?

6. If the men of a camp suffered greatly from enteric irritation how would you proceed to determine the cause? If after inquiry into other causes (here state what other causes might produce such irritation) you have reason to suspect the water as the cause, how would you determine as to its impurity?

7. What are the best means of getting rid of the excrementitious matters of a camp, of a camp hospital, and of a permanent hospital?

Correspondence.

NAVY DEPARTMENT, BUR. MED. AND SURG., November 7, 1862.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—I will be obliged to you, if you can give notice in the MEDICAL TIMES of the 15th inst., that a Board of Naval Surgeons will assemble at the Naval Asylum, Philadelphia, on Monday, Nov. 17th, for the examination of candidates for the appointment of Assistant Surgeon in the Navy.

In addition to the compensation published in the "TIMES" of Oct. 25th, it is proper to add that medical officers, by Act of Congress, approved July 17, 1862, share prize money, "according to their rates of pay in the service."

Very respectfully, your obd't servant,

W. WHELAN.

Army Medical Intelligence.

A Medical Board has been directed to convene at Santa Fé, N. M., to examine Surgeon MCNULTY, of the California Vols., for an appointment in the corps of Volunteer Surgeons.

Assist. Surgeon J. M. ROBINSON, U. S. Vols., has been ordered to report for duty to the Medical Director of the District of Western Virginia, on being relieved by Dr. ALFRED BUCKINGHAM in his duties at Camp Dennison, Ohio.

Surgeon R. CRESSON STILES, U. S. Vols., Surgeon BASIL NORRIS, U.S.A., and Assist. Surgeon WILSON, have been assigned to duty for the examination of drafted men at Pittsburg, Philadelphia, and Harrisonburg, Pa., respectively.

Surgeon D. W. HAND, U. S. Vols., lately in charge of the General Hospital at Newport News, Va., has been ordered to report to the Medical Director at Washington for duty in the Patent Office Hospital.

Surgeon N. R. DERBY, U. S. Vols., has reported to Gen. DAVIS, at Columbus, Ky., as Medical Director of the 4th District, Western Tennessee.

Dr. N. S. DRAKE has been ordered to receive five hundred patients on board the Daniel Webster at Washington, D.C., and proceed with them to Portsmouth Grove, R. I. Assist. Surgeon J. N. MILLER, 120th N. Y. Vols., accompanies them as Assist. to Dr. DRAKE.

Surgeon R. H. ALEXANDER, U.S.A., and Assist. Surgeon W. C. SPENCER, U.S.A., have been assigned to duty with Gen. BANKS, the former as Medical Director, and the latter as Medical Purveyor of the troops of his command.

Surgeon T. H. BACHE, U. S. Vols., is on an inspecting tour of the hospitals at Baltimore, etc.

Surgeon A. B. SHIPMAN, U.S. Vols., recently on duty at the General Hospital, Newport News, Va., is on leave of absence on account of ill health, at Syracuse, N. Y.

Surgeon H. WARDNER, U. S. Vols., has been assigned to duty at Cairo, Ill.

Surgeon I. H. BOUCHER, U. S. Vols., has been ordered to report to Gen. MCPHERSON, at Bolivar, Tenn., as soon as he breaks up the Depot Hospital at Cairo, and turns over the stores, etc., in his possession.

Assist. Surgeon A. M. CLARK, U. S. Vols., has been released from confinement in the Old Capitol Prison and

returned to duty, the charge of having beaten one of his patients not being true.

Dr. Charles Culverwell has been directed to report to Surgeon F. Jacobs, U.S.A., in charge of Convalescent Camp, near Fort Ellsworth, Va.

Assist. Surgeon H. F. Segler, 8th N. Y. Vols, has relieved Dr. H. S. Hendon, on duty with the 6th Battery N. Y. V. Light Artillery.

Surgeon W. Dickinson, U. S. Vols., has been relieved from duty at the General Hospital, Benton Barracks, St. Louis, and ordered to report to the commanding officer, Salem, Mo.

Surgeon Artemas Chapel, U. S. Vols., has returned to duty with the 1st Division, 12th Army Corps, from leave of absence.

Surgeon B. Beust, U. S. Vols., is in charge of the 9th Army Corps Hospital, Knoxville, Md.

Dr. A. B. Crosby of Hanover, N. H., late Brigade Surgeon of Vols., has declined the appointment of Surgeon of Vols., having received an appointment in the Medical Department of Dartmouth College.

Surgeon J. G. F. Holston, U. S. Vols, has been placed in charge of the Overton Hospital at Memphis, Tenn.

Assist. Surgeon E. Dodd, U. S. Vols., has been assigned to duty at Jefferson Barracks, Mo.

Surgeon D. J. McKibbin, U. S. Vols., has reported for duty at the General Hospital, Hilton Head.

Assist. Surgeon L. Taylor, U.S.A., is on duty as member of a Military Board at Fort Steilacoom, W. T.

There are now absent from the Army of the Potomac eighty-six Medical Officers, of whom thirty-five are absent sick, thirty-seven without leave, and fourteen from causes not specified. There are also a considerable number of vacancies in the Medical Staff of the Volunteer regiments.

The Medical Inspector-General having reported unfavorably of the situation and condition of the General Hospital at Annapolis Junction, Md., the Surgeon-General has directed it to be discontinued, and the building to be turned over to the Quartermaster's Department.

The General Hospitals at Craney Island and Newport News, Va., have been broken up; the number of sick in General Dix's Department having been reduced by shipments of sick and wounded soldiers to northern hospitals.

The premises of Messrs. Hatch and Meaker, on North Central Avenue, Baltimore, Md., have been rented by the United States for hospital purposes.

There are now in the 150 General Hospitals of the United States, 60,515 sick and wounded soldiers. Of these 12,665 are in the Western Departments, 17,214 in Washington and vicinity, and the remainder in the various General Hospitals throughout the Atlantic and Gulf States. To attend those properly, it is necessary to keep employed a force of 400 stewards, 300 wardmasters, 6051 male and female nurses, 3025 laundresses, and 2017 cooks, making a total of 72,308 non-combatants; although medical officers are not included. If to these were added the sick in the Departments of the Pacific and New Mexico, those at home and in regimental, brigade, division, army corps, and private hospitals, there is no doubt that the number would be swelled to 100,000.

The Medical Officer in charge of the General Hospital at Judiciary Square, Washington, has been directed to appropriate one of the wards for treatment of diseases of the eye and ear exclusively. Dr. Hildreth has been directed to report to him for special duty in charge of the ward.

On the representation of the Medical Director of the Department of New Mexico, of the importance of his services, the General commanding has suspended the order relieving Surgeon I. F. Gheselin, U.S.A., from duty in that department.

The sick and wounded at Blackwell's Island, New York, have been transferred to Central Park and Newark Hospitals; and the Medical Director at New York has been authorized to remove the sick from the City Hospital, 319 Broadway, N. Y.

J. Theodore Heard, M.D., who had been, since the middle of May last, the Chief Medical Officer of Gen. Duryea's Brigade, was, on the 26th ult., assigned to duty as Chief Medical Officer of the 2d Division (Gen. Rickett's), 1st Army Corps, Army of the Potomac—a position which he temporarily filled from Sept. 10th to Oct. 3d.

DEPARTMENT OF THE TENNESSEE.

The Medical Director of this Department, Surgeon H. R. Wirtz, has issued a circular to the medical officers of the Department, dated at Jackson, Tenn., Oct. 23d. The following Divisions are made:—

1st Division—Gen'l Sherman—south of Hatchee and west of Bolivar. Head-Quarters, Memphis. Division Surgeon, Hartshorn; Chief of General Hospitals, Holston.

2d Division—Gen'l Hurlbut—south of Kentucky line, to Hatchee on the west and to Bethel on the east, including Bolivar. Head-Quarters, Jackson. Division Surgeon, Keenon; Chief of General Hospitals, Strawbridge.

3d Division—Gen'l Hamilton—all south of 1st and 2d Divisions. Head-Quarters, Corinth. Division Surgeon, Campbell; Chief of General Hospitals, Gay.

4th Division—Gen'l Davies—all north of the 2d Division, including the District of Cairo, and of the Mississippi, Forts Henry and Donelson, &c. Division Surgeon, Derby; Chief of General Hospitals, Stearns.

H. R. Wirtz, *Medical Director.*

Medical News.

Death of Sir Benjamin C. Brodie, Bart., F.R.S.—On the evening of the 21st October, was added to the number of the departed, a man to whom the unanimous consent of the profession has long given a pre-eminent position amongst us. We need hardly mention the name—Sir Benjamin Brodie. For a long time, the state of his health has been such as to cause much anxiety both to his immediate friends and to the members of his profession. Laboring under the severe affliction of blindness, he has undergone four operations in his eyes without success; and he has, moreover, suffered from a painful affection of the bladder, and malignant disease of the shoulder-joint. At last, full of years, full of honors, and rich in the well earned rewards of his scientific knowledge and its skilful application to the relief of suffering humanity, this great surgeon has left the world.—*Brit. Jour.*

The following-named Surgeons in the State of New York are appointed for the several places of rendezvous, and will report for duty to the Commandants: Albany, S. D. Willard; Yonkers, Geo. B. Upham; Plattsburgh, William N. Coit; Fonda, Jeremiah Snell; Auburn, Edward Hall; Elmira, E. L. Hart; Buffalo, J. S. Trowbridge.

M. Bouchat tells us that he has studied meningitis by the aid of the ophthalmoscope. He discovered congestions and venous dilatations, varicosity and flexusity of veins, thrombosis of veins and hæmorrhages in the retina from rupture of vessels!

Professor Esterle of Novaro has died at the age of forty-four, from purulent infection, contracted while attending a difficult labor.

The Francisco journals state that Dr. Bodinier, a French physician, was drowned at the time of the burning at sea of the *Golden Gate.*

The Ophthalmic Congress has selected Vienna as the place of its next annual meeting, and has appointed Arlt, Blodig, Gulz, Jäger, sen. and jun., and Stedwig, as committee-men.—*Brit. Jour.*

The last report of the Government Inspectors of Mines tells us: that, for every 74,674 tons of coals raised a human life is sacrificed.—*Brit. Jour.*

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 3d day of November to the 10th day of November, 1862.

Deaths.—Men, 87; women, 71; boys, 90; girls, 61; total, 309. Adults, 158; children, 151; males, 177; females, 132; colored, 14. Infants under two years of age, 87. Children born of native parents, 14; foreign, 122.

Among the causes of death we notice:—Apoplexy, 1; infantile convulsions, 18; croup, 25; diphtheria, 16; scarlet fever, 3; typhus and typhoid fevers, 7; consumption, 61; small-pox, 2; measles, 2; dropsy of head, 8; infantile marasmus, 16; cholera infantum, 2; inflammation of brain, 10; of bowels, 5; of lungs, 16; bronchitis, 5; congestion of brain, 9; of lungs, 5; erysipelas, 0; diarrhœa and dysentery, 12. 158 deaths occurred from acute diseases, and 25 from violent causes. 100 were native, and 209 foreign; of whom 75 came from Ireland; 87 died in the City Charities; of whom 11 were in Bellevue Hospital, and 1 died in the Immigrant Institution.

Abstract of the Atmospherical Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

Nov. 1862	Barometer. Mean height.	Barometer. Daily range.	Temperature. Mean	Temperature. Min.	Temperature. Max.	Difference of dry and wet bulb. Therm. Mean	Difference of dry and wet bulb. Therm. Max.	Wind.	Mean amount of cloud.	Humidity. Saturation, 1000
	In.	In.	°	°	°	°	°			
1st.	30.08	.14	60	54	64	9	12	S.W.	1	510
2d.	29.81	.40	56	50	64	7	11	S.	3	590
3d.	29.84	.40	48	43	56	9	12	SW to NW	2	484
4th.	30.20	.20	41	32	50	9	13	N.W.	.04	450
5th.	30.07	.30	50	40	60	5	8	S.	8	698
6th.	29.81	.18	35	30	43	7	12	SW to NW	9	567
7th.	29.64	.24	26	24	32	2	4	N.E.	10	840

REMARKS.—1st, Fine. 2d, Clear A.M., variable P.M. 3d, Clear A.M.' variable P.M. with fresh wind. 4th, Clear, fresh all day. 5th, Variable A.M., cloudy P.M. 6th, Wind, fresh all day; rain early A.M.; sky obscured nearly all day. 7th, Great Autumnal storm extending over the whole country and far at sea; commenced in Minnesota early on the 6th. Its progress was much more rapid and extensive than usual. Heavy snow commenced falling in New York at 7 A.M., followed by cold sleet P.M. Rain and melted snow for the week an inch; for the previous week three inches.

SPECIAL NOTICES.

THE NEW YORK ACADEMY OF MEDICINE.—*"Albuminuria" in* ALL *its relations, will come up for* GENERAL *discussion (probably the last) on Wednesday, November* 19.

N. Y. OPHTHALMIC SCHOOL.—DR. MARK STEPHENSON *will lecture at the N. Y. Ophthalmic Hospital, cor. Fourth Ave. and Twenty-Eighth St., every Saturday, at 4½ o'clock P.M. The members of the class will meet twenty minutes earlier for a review and examination of the preceding lecture. Clinique and operating days,* Tuesday *and* Thursday, *at 1½ o'clock P.M. To be continued till March* 1, 1863.

New England Mutual Life Ins. Co., BOSTON AND NEW YORK, ORGANIZED 1843. **ASSETS, $2,350,000.** Documents showing the benefits of Life Insurance with the advantages of the Mutual plan, and the superior position and marked success of this Co., and explaining the different kinds of Policies with their methods of payment, may be obtained free of expense, upon application, either personally or by mail, to JOHN HOPPER, Agent and Attorney for the Co., Metropolitan Bank Building, 110 Broadway, New York. ☞ *Parties at a distance may insure from Blanks, which will be forwarded free of expense.*

To the Medical Profession.—Dr. I. PARIGOT, Honorary Professor of the University of Brussels, late Commissioner in Lunacy, and Superintendent of Gheel, has opened an Institution at *Hastings, on the Hudson,* for the cure of mental and nervous diseases. The house is situated in a delightful and retired spot near the Hudson with vast grounds and gardens. The system employed in this new institution (that of *free air and family life*) is based upon the moral and physical liberty of the patients who voluntarily submit to medical treatment.

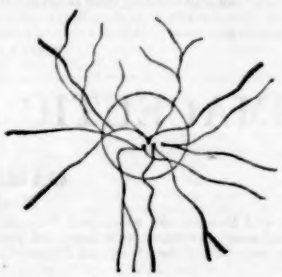
Dr. P. is permitted to give for his references several gentlemen of the highest scientific authority, and Superintendents of Asylums of the United States. In town he may be consulted at Dr. Eisberg's office, 153 West 15th street, on Tuesdays and Saturdays, for mental diseases and medico-legal questions.

Clinical Essays, by B. W. Richardson, M.D. 8vo. London, 1862. $2.60.
BAILLIERE BROTHERS, 440 Broadway, N. Y.

Dr. Churchill's Hypophosphites.
PREVENTION AND CURE OF CONSUMPTION
A supply of these important medicines,
SYRUP OF HYPOPHOSPHITE OF SODA,
SYRUP OF HYPOPHOSPHITE OF LIME,
PILLS OF HYPOPHOSPHITE OF QUININE,
PILLS OF HYPOPHOSPHITE OF MANGANESE,
has arrived from Paris with directions for use. Persons suffering from chest affections can now procure the above preparations genuine, as used by Dr. Churchill from the following agents in America.
Messrs. Hegeman & Co., Broadway, New York, Mr. F. Brown, corner of Fifth and Chestnut Streets, Philadelphia; Messrs. T. Metcalfe & Co., Boston; Messrs. J. T. Brown & Sons, 425 Washington Street, Boston.
Wholesale orders to be addressed to H. H. SWANN, Pharmacien, 12 rue Castiglione, Paris.

The original "Elixir of Calisaya BARK."—This elegant and valuable medicinal preparation was introduced to the notice of the Faculty of this city in 1840, by *J. Milhau, the sole Inventor and Manufacturer,* at which date none of those numerous firms were in existence, who, rather than give a new name to a new article, have found it more convenient within a few years to appropriate the above extensively and favorably known title: it is therefore presumable that physicians in prescribing, as for over thirty years, have reference solely to the *original article* made by
J. MILHAU & SON,
Wholesale Druggists and Pharmaceutists, 183 Broadway, N. Y.
Sole agents for FRENCH ARTIFICIAL EYES, have always a large assortment on hand, and will furnish to order a single eye, of any desired pattern, in thirty days. Agents for the majority of, and importers of all the French medicines in vogue.

American Journal of Ophthalmology
JULIUS HOMBERGER, M.D., EDITOR.



No. 2, for September, just published.
Subscription Price for one year (six numbers), $2.00; sample numbers free.
BAILLIERE BROTHERS,
440 Broadway, New York.

COOPER'S
Dictionary of Practical Surgery
AND
ENCYCLOPÆDIA OF SURGICAL SCIENCE.
New Edition, brought down to the present time, by SAML. A. LANE, assisted by various eminent surgeons. In 2 Vols. Vol. I., 8vo. London, 1861. $10.00.
BAILLIERE BROTHERS, 440 Broadway, N. Y.

On Urine, Urinary Deposits, and CALCULI: Their Microscopical and Chemical Examination, including the Chemical and Microscopical Apparatus required, and Tables for the Practical Examination of the Urine in Health and Disease; by Lionel S. Beale, M.D. Illustrated with numerous original Wood Engravings. Post 8vo. London, 1861. Price $3.40.
BAILLIERE BROTHERS, 440 Broadway, N. Y.

Diagrams of the Nerves of the Human Body, exhibiting their Origin, Divisions, and Connexions, with their Distribution to the Various Regions of the Cutaneous Surface and to all the Muscles, by W. H. Flower, M.D. Folio. London, 1861. $5.60.
BAILLIERE BROTHERS, 440 Broadway, N. Y.

On the Various Contrivances by which British and Foreign Orchids are fertilized by Insects, and on the good effects of Intercrossing. By Charles Darwin, M.A., F.R.S., etc. 8vo. London, 1862. $3.60.
BAILLIERE BROTHERS, 440 Broadway, N. Y.

Just published, 12mo., 260 pages. Price $1.25. Free by mail on receipt of the price.

ON MILITARY AND CAMP HOSPITALS,

AND THE

HEALTH OF TROOPS IN THE FIELD.

BY L. BAUDENS,

MEDICAL INSPECTOR OF THE FRENCH ARMY, ETC., ETC.

TRANSLATED AND ANNOTATED BY FRANKLIN B. HOUGH, M.D.,

LATE SANITARY INSPECTOR IN THE ARMY OF THE POTOMAC.

*** The above work is the result of a commission sent by the French Government to the Crimea to report upon the condition of the Hospitals and troops of the French army, and incidentally of the English and Sardinian armies. It is written in the form of a narrative, and the great questions of the *prevention and control of disease in camps and hospitals* are thoroughly discussed. The hygienic conditions of the United States Army are similar to those of the armies of the Crimea; the rules and prescriptions given in the book will, therefore, be found perfectly applicable. This work recommends itself to commanders of regiments as well as army surgeons.

From Buffalo Medical Surgical Journal, August, 1862.

The Medical Topography of the Crimea is given in the first chapter and a description of the camps, hospitals, and many other circumstances and conditions of the army are included, together with the geological features of that country. It constitutes a very entertaining and instructive section.

The second chapter is upon rations, and a very minute and reliable account is given of the character, amount, and cost, of soldiers' food

Chapter 3d—*Camps and Shelters.*—Contains a full description of the construction, location, drainage, ventilation, and other hygienic conditions of the camps, shelters, and hospitals.

Chapter 4th—*Clothes.*—This matter of clothes is a very important one, not only in the view of the soldier, but also in the estimation of the Sanitary Commissioner; many valuable suggestions are made upon the subject of dress.

Part II. is upon *Infirmaries* and *field* hospitals, surgical operations, physicians, chloroform, &c., &c.

Part III. is devoted to hospitals and their diseases, cholera, typhus, &c., &c., in the Crimea, to which is added an appendix, containing many valuable statistics.

This is one of the most readable books we have seen, telling the physician everything he would most desire to know about the Crimean war, and the results of surgical military practice everywhere. It is so attractive and easy in style, that intelligent men of all classes would be greatly interested in it; much of its teaching would be as useful to the military officer as to the surgeon. It is full of suggestions upon the whole subject of military science, though the main facts and observations have reference to the medical provision and treatment of the army.

It is a valuable book, and while we earnestly recommend it to the perusal of physicians, we also bespeak for it consideration, as an open fountain of experience and observation, from which all may draw instruction and entertainment.

BAILLIERE BROTHERS, 440 BROADWAY, N. Y.

PHARMACEUTIC GRANULES AND DRAGEES

(*Sugar Coated Pills*)

of

GARNIER, LAMOUREUX & Co.

Members of the College of Pharmacy, of Paris.

These Granules and Dragees are recognised, both in Europe and in the United States, as the most reliable way of dispensing valuable medicines. Physicians will find many worthless imitations, and they must be careful to see that the Pills dispensed by the druggists are made by Messrs. Garnier, Lamoureux & Co., members of the College of Pharmacy of Paris. The following are some of the principal preparations:

DRAGEES.

	U. S. P.		U. S. P.		U. S. P.
Aloes and Myrrh	4 grs.	Compound Squills	4 grs.	Valerianate of Iron	1 grs.
Compound Cathartic	3 "	Dover's Powders	3 "	Citrate of Iron and Quinine	2 "
" "	1½ "	Carbonate Iron, Vallet's formula		" " Iron	2 "
Aloetic	4 "	Carbonate of Manganese and Iron		Willow Charcoal	2 "
Assafœtida	4 "	Kermes	1-5 "	Diascordium	2 "
Aloes and Assafœtida	4 "	Santonine	½ "	Anderson's Antibilious and Purgative	2 "
Dinner, Lady Webster's	3 "	Bi-Carbonate of Soda	4 "	Extract of Gentian	2 "
Compound Calomel, Plummer's	3 "	Magnesia and Rhubarb	1 "	Iodide of Potassium	2 "
" " "	1½ "	Quevenne's Iron Reduced by Hydrogen	1 "	Calcined Magnesia	2 "
Blue Pills	8 "	Meglin	1 "	Rhubarb	2 "
Opium Pills	1 "	Cynoglosse	1 "	Ergot Powder, covered with Sugar as soon as pulv'd	2 "
Calomel Pills	2 "	Proto-Iodide of Iron	1 "	Phyllandria Seed	2 "
Opium et Acet. Plumb. each	1 "	Lactate of Iron	1 "	Washed Sulphur	2 "
Extract of Rhatany	2 "	Sulphate of Quinine	1 & 2 "	S. N. Bismuth	2 "
Compound Rhubarb	3 "	Valerianate of Quinine	1 "	Tartrate Potassa and Iron	2 "
Compound Colocynth	3 "	" " Zinc	1 "		

GRANULES.

Of 1-50 of a grain each.

Aconitine.
Atropine.
Digitaline.

Morphine.
Strychnine.

Valerianate of Atropine.
Veratrine.

Of 1.5 of a grain each.

Tartar Emetic.
Codeine.
Conicine.

Extract of Belladonna.
" " Hyosciamus.
" " Ipecac.

Extract of Opium.
Proto-Iodide of Mercury.

Lupuline	½ grn.	Nitrate of Silver	½ grn.	Acetate Morphine	⅛ grn.
Extract Nux Vomica	½ "	Extract of Hyosciamus	½ "	Digitaline	1-24 "
Veratrine	1-24 "	Extract Rad. Aconite	¼ "	Strychnine	1-12 "
Arsenious Acid	1-24 "	Emetine	¼ "	Colchicum (each granule equal to two drops of tincture).	
Sulphate of Morphine	⅛ "	Iodide of Mercury	¼ "		
Corrosive Sublimate	1-12 "	Valerianate Morphine	¼ "		

DRAGEES.

Copaiba, pure solidified.
Copaiba and Cubebs.

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